DCC Delaware Correctional Center
Smyrna Landing Road
SMYRNA DE, 19977
Phone No. 302-653-9261

Date: 08/03/2006

Exhibits ID-1

GRIEVANCE INFORMATION - Appeal

OFFENDER GRIEVANCE INFORMATION

Offender Name	: BAYLIS, LEONARD K	**SBI#**	: 00100231	**Institution**	: DCC
Grievance #	: 22328	**Grievance Date**	: 11/29/2005	**Category**	: Individual
Status	: Unresolved	**Resolution Status**	:	**Inmate Status**	:
Grievance Type	: Health Issue (Medical)	**Incident Date**	: 11/29/2005	**Incident Time**	: 13:00
IGC	: Merson, Lise M	**Housing Location**	: Bldg 23, Lower, Tier D, Cell 3, Bottom		

APPEAL REQUEST

Appeal arrived Thursday 3 August 2006: It has been well over a year since I have been scheduled to have dental work - However no actual dental work has been accomplished.
I appeal to the grievance board for an investigation vis a vis actual dental work vs. words on paper. This to the extent that I actually receive dental work.
I am experiencing stomach problems because of difficulty chewing food and digesting food.

REMEDY REQUEST

Exhibits D-2

Delaware Department of Correction
Health Care Services Fee Sheet

Inmate Name Baylis Leonard **SBI #** 00231

(Last, First MI)

Urine given - 8-15-06
Digestion

Facility JCC **Date** 8-16-06

✓	**Chargeable Visit**	**$4.00**
___	**Non Chargeable Visit**	**-0-**
___	**Medication Handling Fee ($2.00 X 2)**	**$4.00**
	Total Amount Charged To Inmate Account	**$8.00**

Health Care Staff Signature: KC

I CERTIFY BY MY SIGNATURE THAT I HAVE RECEIVED THE SERVICES DESCRIBED ABOVE.

Inmate Signature: [signature] **Date:** 8-16-06

1) *Witness Signature: _____ **Date:** _____

2) *Witness Signature: _____ **Date:** _____

The fee for services rendered will be deducted from your inmate account even if the amount deducted generates a negative balance. Any funds received by you will first be applied to any negative balance. Any negative balance remaining on your account when you are released will remain active for three (3) years after the date of release. Should you return to Delaware Department of Correction as an inmate within that three (3) year period, the negative balance will be applied to your inmate account on your new commitment.

Distribution:
Original: Facility Business Office Posted/Entered by_____ Date_____
Copy: Inmate Medical Record (yellow)
Inmate (pink)

*Only needed if inmate refuses or is unable to sign.
FORM #: 621

3 part NCR

(C:Copay.96:Form.4)

Exhibits D-3

Delaware Department of Correction
Health Care Services Fee Sheet

Inmate Name Baylis Leonard **SBI #** 100381
(Last, First MI)

Difficulty w Digestion Defecating (urine)

Facility DCC **Date** 6/5/06

___	**Chargeable Visit**	**$4.00**
✓	**Non Chargeable Visit**	**-0-**
___	**Medication Handling Fee ($2.00 X _____)**	**$_____**
	Total Amount Charged To Inmate Account	**$ 0**

Health Care Staff Signature: KC

I CERTIFY BY MY SIGNATURE THAT I HAVE RECEIVED THE SERVICES DESCRIBED ABOVE.

Inmate Signature: [signature] **Date:** 6-5-06

1) *Witness Signature: _____ **Date:** _____

2) *Witness Signature: _____ **Date:** _____

The fee for services rendered will be deducted from your inmate account even if the amount deducted generates a negative balance. Any funds received by you will first be applied to any negative balance. Any negative balance remaining on your account when you are released will remain active for three (3) years after the date of release. Should you return to Delaware Department of Correction as an inmate within that three (3) year period, the negative balance will be applied to your inmate account on your new commitment.

Distribution:
Original: Facility Business Office Posted/Entered by_____ Date_____
Copy: Inmate Medical Record (yellow)
Inmate (pink)

*Only needed if inmate refuses or is unable to sign.
FORM #: 621

3 part NCR

(C:Copay.96:Form.4)

Exhibits D- 4

Delaware Department of Correction
Health Care Services Fee Sheet

Inmate Name Bayliss, Leonard **SBI #** 100231
(Last, First MI) Difficulty Digesting

Facility DCC **Date** 7/31/06

___	**Chargeable Visit**	**$4.00**
___	**Non Chargeable Visit**	**-0-**
___	**Medication Handling Fee ($2.00 X _____)**	**$_____**

Total Amount Charged To Inmate Account **$ 0**

Health Care Staff Signature: KC

I CERTIFY BY MY SIGNATURE THAT I HAVE RECEIVED THE SERVICES DESCRIBED ABOVE.

Inmate Signature: [signature] **Date:** 7/31/06

1) *Witness Signature: _____ **Date:** _____

2) *Witness Signature: _____ **Date:** _____

The fee for services rendered will be deducted from your inmate account even if the amount deducted generates a negative balance. Any funds received by you will first be applied to any negative balance. Any negative balance remaining on your account when you are released will remain active for three (3) years after the date of release. Should you return to Delaware Department of Correction as an inmate within that three (3) year period, the negative balance will be applied to your inmate account on your new commitment.

Distribution:
Original: Facility Business Office Posted/Entered by_____ Date_____
Copy: Inmate Medical Record (yellow)
Inmate (pink)

*Only needed if inmate refuses or is unable to sign.
FORM #: 621

3 part NCR

(C:Copay.96:Form.4)